EXPLORING THE RELATIONSHIP OF CONSPIRACY BELIEFS ABOUT HIV/AIDS TO SEXUAL BEHAVIORS AND ATTITUDES AMONG AFRICAN-AMERICAN ADULTS

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Conspiracy beliefs about HIV/AIDS have been endorsed by significant percentages of African Americans in prior research. However, almost no research has investigated the relationship of such beliefs to behaviors and attitudes relevant to HIV risk. In the present exploratory study, 71 African-American adults (aged 18–45; 61% female) in the United States participated in a national, cross-sectional telephone survey examining the relationship of HIV/AIDS conspiracy beliefs to sexual attitudes and behaviors. Results indicated significant associations between endorsement of a general HIV/AIDS government conspiracy and negative beliefs regarding condoms and greater numbers of sexual partners. Endorsement of HIV/AIDS treatment conspiracies was related to positive attitudes about condoms and greater condom use intentions. Findings suggest that conspiracy beliefs have implications for HIV prevention in African-American communities. (*J Natl Med Assoc.* 2003;95:1057-1065.)

Key words: HIV/AIDS ♦ attitudes ♦ African Americans ♦ sexual behavior ♦ conspiracy beliefs

African Americans are disproportionately affected by HIV/AIDS[1,2]. Comprising only 12% of the U.S. population, African Americans accounted for 47% of the total number of U.S. AIDS cases reported in 2000 and 49% of the total number reported in 2001. Moreover, the annual rate of U.S. AIDS cases reported in 2001 among non-Hispanic black men was 109.2 per 100,000—over seven times the rate among non-Hispanic white men (13.7 per 100,000). Similarly, the rate among non-Hispanic black women in 2001 was 47.8 per 100,000—nearly 20 times the rate among non-Hispanic white women (2.4 per 100,000).

Clearly, HIV prevention is essential within African-American communities. However, several barriers to HIV prevention among African Americans have been identified. In particular, research suggests that attitudes toward health care are more negative among African Americans than among whites, with African Americans reporting greater racism in health care and mistrust of the health care system[3,4]. Researchers have feared that African Americans' negative attitudes regarding health care can be an impediment to the dissemination and acceptance of public health prevention messages[5,6]. These negative attitudes may stem from historical and current discrimination within the health care system. The most striking example of such discrimination is the Tuskegee Syphilis

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Study, in which the public health service studied the effects of untreated syphilis in African-American men for 40 years[5-9]. Although an effective treatment for syphilis became available during the course of the study, participants in the study were not offered treatment.

Some African Americans' negative attitudes about health care have been exhibited in the form of conspiracy beliefs. A handful of empirical studies have observed that a significant percentage of African Americans hold conspiracy beliefs regarding HIV/AIDS[10-14], including the belief that HIV/AIDS is a form of black genocide. Herek and Glunt[11] conducted a national telephone survey in which they found that two-thirds of blacks (67%) compared to one-third of whites (34%) agreed that the government is not telling the whole story about AIDS. In another national telephone survey, Herek and Capitanio[10] found that 20% of blacks, compared to 4% of whites, agreed with the statement, "The government is using AIDS as a way of killing off minority groups." In addition, 43% of African Americans and 37% of whites agreed that, "A lot of information about AIDS is being held back from the general public." Among African Americans in their sample, lower levels of education and income were associated with the belief that the government is using AIDS as a way of killing off minority groups. Neither of the conspiracy beliefs was significantly related to self-reported behavior change as a result of AIDS (i.e., changes in respondents' risk behavior as a result of AIDS, such as reducing their numbers of sexual partners or increasing their use of condoms).

Thomas and Quinn[14] reported findings regarding HIV/AIDS conspiracy beliefs from a number of surveys with diverse black samples. Depending on the sample, between 28% and 44% of respondents indicated that they did not trust government reports about AIDS. Between 17% and 38% of respondents believed that there is some truth in reports that the AIDS virus was produced in a germ-warfare laboratory. Between 15% and 35% agreed that AIDS is a form of genocide against the black race. Similarly, in a 1996 survey of African-American parishioners of 35 churches in Louisiana, almost 70% of respondents did not believe that the government is telling the truth about AIDS, and over 25% agreed that AIDS was "intended to wipe blacks off the face of the earth."[13]

More recently, Klonoff and Landrine[12] surveyed black adults door-to-door in 10 randomly selected middle- and working-class census tracts in San Bernardino County, CA. Respondents reported their agreement with the statement, "HIV/AIDS is a manmade virus that the federal government made to kill and wipe out black people." Although 33% of the respondents totally disagreed and 18% somewhat disagreed with the statement, 14% totally agreed, 12% somewhat agreed, and 23% were undecided. In analyses of the entire sample, men, individuals who were culturally traditional (i.e., immersed in different dimensions of black culture, including, for example, traditional family practices, traditional health beliefs and practices, and religious beliefs and practices), individuals who more frequently perceived discrimination in their lifetime, and individuals who had higher levels of education (i.e., college versus high-school graduates) were more likely to endorse the statement. Among men, reports of more frequent, perceived, lifetime discrimination and less frequent, perceived, recent discrimination were associated with agreeing with the conspiracy belief. Among women, being culturally traditional was associated with endorsing the conspiracy belief.

Overall, prior work has demonstrated the prevalence of conspiracy beliefs among African Americans. However, the degree to which such beliefs are barriers to HIV prevention has not received much empirical attention. We found only one study[10] that examined the relationship between belief in an HIV/AIDS conspiracy and sexual behavior, and the association was not significant. In addition, the researchers did not examine a full range of sexual behavior and attitudes, such as attitudes toward condom use and condom use behaviors. Such research would be useful in pinpointing the influence of conspiracy beliefs on sexual health. It is likely, for example, that HIV/AIDS conspiracy beliefs impact individuals' acceptance of HIV prevention methods, such as condoms, although this hypothesis has never been explored.

Research assessing the relationship of conspiracy beliefs to sexual behavior and attitudes is crucial for understanding whether and how such beliefs may be barriers to HIV prevention among African Americans. Due to the relative lack of research in the area of HIV/AIDS conspiracy beliefs and sexual risk, we conducted an exploratory, cross-sectional study examining the relationship of such beliefs to sexual behavior and attitudes toward condoms among African-American adults. We assessed participants'

agreement with a broader range of HIV/AIDS conspiracy beliefs than have been examined previously, from more extreme beliefs regarding the creation of AIDS by the government to milder beliefs that the government is withholding information. In addition, we examined endorsement of two types of HIV/AIDS conspiracy beliefs: those regarding general government HIV/AIDS conspiracies (e.g., "AIDS is a form of genocide against African Americans") and those regarding conspiracies about new treatments for HIV (e.g., "People who take the new medicines for HIV are human guinea pigs for the government"). Although documented in the popular press[15,16], treatment-related conspiracy beliefs have not been examined empirically.

We were particularly interested in identifying those aspects of conspiracy beliefs that are most prevalent and most likely to affect HIV prevention efforts. We therefore explored the association of HIV/AIDS conspiracy beliefs to a set of beliefs and behaviors relevant to sexual health, including men's and women's attitudes toward condoms, condom use intentions and behaviors, and numbers of sexual partners. Our aim was to demonstrate initial support for the relationship between conspiracy beliefs and these sexual behavior and attitude variables. Such information would provide a basis for more large-scale studies with the ultimate goal of integrating and addressing specific conspiracy beliefs within the context of HIV prevention interventions.

METHOD

Design and Sample

A national sample of blacks/African Americans (aged 18–45 years) participated in a cross-sectional, anonymous telephone survey from May to July 2001. Telephone numbers were purchased from Survey Sampling, Inc. (Fairfield, CT) for two random-digit dial (RDD) samples and two samples of listed numbers. To increase the likelihood of reaching black households, the numbers for the two RDD samples were selected from exchanges with estimated black household densities of 20% or greater and 40% or greater (based on 1990 U.S. census data), and the numbers for the two listed samples were selected from U.S. census tracts with black household densities of 20% or greater and 40% or greater. The listed numbers were selected using a national database of U.S. households containing telephone numbers from all U.S. White-Page telephone directories, supplemented with auto registration data when available. (This heterogeneous sample design allowed us to explore the best methodologies for larger-scale future research of this type.)

The target person in each household was the African-American adult (aged 18–45) who last had a birthday. To be eligible, potential respondents had to report that they were 18–45 years of age and respond affirmatively to the question, "Do you consider yourself to be black or African-American?" Of the 1,803 numbers in the sample, 537 (30%) were businesses or out-of-order, 332 (18%) were numbers for which 10–20 dial attempts were made without anyone answering, 22 (1%) were numbers for which we obtained no answer but did not reach the maximum dial attempts, and 911 (51%) were determined to be residential households. Of those 911 numbers, 801 (88%) were for ineligible households (due to race/ethnicity, age, language, or mental capabilities), nine (1%) were for households in which someone refused before eligibility could be determined, and 101 (11%) were identified as eligible households. Those 101 numbers resulted in 71 (70%) completed interviews.

Data Collection

The interviews were conducted by Applied Research Northwest (ARN; Bellingham, WA). All interviewers underwent project-specific training. The interviews were conducted using ARN's computer-aided telephone interviewing system. Interviewers screened potential respondents for eligibility. Eligible respondents were told that the interview concerned discrimination, HIV, and birth control. Verbal consent was obtained prior to conducting each interview. The interviews averaged 20 minutes in length.

Measures

This study was part of a larger exploratory investigation examining African Americans' beliefs and behaviors regarding birth control, HIV, and reproductive health care[17]. (Our previous research from this dataset focused on conspiracy beliefs about birth control.) In the present investigation, we focused on the following measures:

Sociodemographic Characteristics. We assessed participants' age, gender, marital status, education, employment status, number of living children, and annual household income and the number of people supported by that income.

Participants were also asked if they were born outside of the United States (yes/no) and if they were currently living with a partner (yes/no).

HIV/AIDS Conspiracy Beliefs. Participants were asked to report the extent to which they agreed or disagreed with 10 statements tapping belief in HIV/AIDS conspiracy theories, most of which were adapted from prior research[5,10-14,18,19]. Response options were: "disagree strongly," "disagree somewhat," "no opinion," "agree somewhat," and "agree strongly." Seven of these statements concerned belief in HIV/AIDS conspiracies about the government: "A lot of information about AIDS is being held back from the public," "HIV is a manmade virus," "AIDS is a real public health threat," "There is a cure for AIDS, but it is being withheld from the poor," "The government is telling the truth about AIDS," "AIDS is a form of genocide against African Americans," and "AIDS was created by the government to control the African-American population." Because the distribution of responses to one of the statements, "AIDS is a real public health threat," was highly positively skewed and did not show sufficient variability (i.e., 87% strongly agreed, and 10% somewhat agreed with the statement), it was dropped from further analysis. The remaining six items were averaged and combined into one overall scale (α=0.77), with higher scores indicating greater belief in HIV/AIDS government conspiracies. One item, "The government is telling the truth about AIDS," was reverse-scored prior to inclusion in the scale.

Three of the statements concerned beliefs in conspiracies about new treatments for HIV: "The medicine used to treat HIV causes people to get AIDS," "The medicine that doctors prescribe to treat HIV is poison," and, "People who take the new medicines for HIV are human guinea pigs for the government." These three beliefs were combined to form one overall scale (α=0.73); higher scores indicated higher endorsement of HIV/AIDS treatment conspiracies.

Condom Use Intentions and Sexual Behavior. Men were asked the number of female sexual partners they had in their lifetime, and women were asked the number of male sexual partners they had in their lifetime. Participants who indicated ever having an opposite-sex partner were asked the likelihood of condom use at next intercourse, with response options "very unlikely," "somewhat unlikely," "neither likely nor unlikely," "somewhat likely," and "very likely." They were also asked the number of times in the past three months that they had sexual intercourse, the number of those times that they had used a condom, and the numbers of partners with whom they had intercourse in the past three months. Sexual intercourse was defined to participants as "vaginal or anal intercourse." To measure condom use, we calculated the percentage of times each respondent had used condoms when they had sexual intercourse in the past three months. Because the distribution of condom use was non-normal, we recoded the condom use percentages into "never" (0% of the time; n=24, 55% of participants who had intercourse in the past three months) versus "sometimes or always" (greater than 0% of the time; n=20, 45% of participants who had intercourse in the past three months. (Male participants were asked if they ever had a male sexual partner, and female participants were asked if they ever had a female sexual partner. Only one male participant and three female participants indicated ever having had a same-sex sexual partner.)

Condom-Related Attitudes. Respondents who had at least one opposite-sex partner in their lifetime rated the extent to which using a condom every time they have sex in the next three months would be pleasant or unpleasant (1=very unpleasant to 5=very pleasant) and good or bad (1=very bad to 5=very good). These two items were averaged for an overall measure of attitudes toward condom use (α=0.65).

Because condoms are a method of contraception as well disease prevention, we were also interested in the relationship between HIV/AIDS conspiracy beliefs and attitudes toward condoms as a birth-control method. All participants were asked to rate the quality of condoms as a method of birth control on a scale from 1 (very bad method) to 5 (very good method).

Statistical Analyses

Statistical analyses were conducted to determine whether endorsement of conspiracy beliefs varied by sociodemographic characteristics, condom-related attitudes, and sexual behavior. Separate analyses were done for each conspiracy belief scale (i.e., the HIV/AIDS government conspiracy scale and the HIV/AIDS treatment conspiracy scale). In analyses of the sociodemographic characteristics and sexual risk attitudes, intentions, and behaviors, Pearson correlations were conducted for continuous variables, and point-biserial cor-

relations were performed for dichotomous variables. Because the distributions of numbers of partners in lifetime and in the last three months were non-normally distributed, we calculated the log of these variables. The results for the transformed and nontransformed variables did not differ in terms of significance level; we therefore present findings for the nontransformed variables.

Table 1. Respondents' Sociodemographic Characteristics

Sociodemographic Characteristic	%/M(SD)
Gender (%)	
Male	39.4
Female	60.6
Born outside the United States (%)	9.9
Age in years (%)	
18-25	21.1
26-35	42.3
36-45	36.6
Mean age in years (SD)	32.7 (8.1)
Currently living with a partner (%)	50.7
Current marital status (%)	
Married	35.2
Divorced or separated	18.3
Never married	46.5
Education (%)	
High school, GED, or less	42.3
Some college or more	57.7
Currently working (%)	76.1
Annual household income[a] (%)	
Less than $25,000	33.3
$25,000 or greater	66.7
Number of people income supports[b] (%)	
1–2	41.5
3	23.1
4	35.4
Number of living children, regardless of age (%)	
None	31.0
1	19.7
2	49.3

a Four respondents reported 'don't know,' and data were missing for one respondent. 'Don't know' responses and missing data were not included in calculations of percentages; n=66

b One respondent reported 'don't know,' and data were missing for five respondents. The 'don't know' response and missing data were not included in calculations of percentages; n=65.

RESULTS

Sample Characteristics

Due to our eligibility criteria, all respondents were black/African-American. As shown in Table 1, 61% of the respondents were women. The average age was approximately 33 years, with a range of 18–45. Over half were currently living with a partner, and 35% were married at the time of the interview. The majority (58%) had at least some college education, although a substantial proportion (42%) had a high-school diploma/GED or less. About three-quarters were currently employed. Two-thirds had annual household incomes of $25,000 or greater. Almost a third had no living children, and about half had two or more living children; 20% had only one living child. None of the sociodemographic characteristics were significantly related to scores on either of the HIV/AIDS conspiracy belief scales.

Endorsement of HIV/AIDS Conspiracy Beliefs

As shown in Table 2, many respondents endorsed conspiracy beliefs about HIV/AIDS. For instance, the majority (70%) somewhat or strongly believed that, "A lot of information about AIDS is being held back from the public," and over half somewhat or strongly endorsed the statement that, "There is a cure for AIDS, but it is being withheld from the poor." Moreover, almost 60% disagreed that, "The government is telling the truth about AIDS." Overall, fewer participants endorsed treatment-related conspiracy beliefs, although over 40% somewhat or strongly agreed that, "People who take the new medicines for HIV are human guinea pigs for the government." Scores on the HIV/AIDS government conspiracy scale averaged around the midpoint (M=2.94, SD=1.06), with a range of 1.17 to 4.83; and scores on the HIV/AIDS treatment scale were slightly lower (M=2.20, SD=1.05), with a range of 1.00 to 4.33. The two scales were significantly moderately correlated (r=0.46, p<0.001).

Relationship of Sexual Attitudes, Intentions, and Behaviors to HIV/AIDS Conspiracy Beliefs

As shown in Table 3, greater endorsement of an HIV/AIDS government conspiracy was related to lower perceived quality of condoms as a method of birth control and greater numbers of partners in the past three months. In contrast, belief in an HIV/AIDS treatment conspiracy was related to more positive attitudes about using condoms in the next three months and greater intentions to use condoms at next intercourse, and marginally related to using condoms in the past three months. Neither type of conspiracy belief was significantly associated with the number of partners in a lifetime.

DISCUSSION

The goals of the present exploratory study were to measure the extent to which conspiracy beliefs about HIV/AIDS were endorsed among a small random sample of African-American adults and to evaluate whether such beliefs might be barriers to HIV prevention in African-American communities. We assessed a wider range of conspiracy beliefs than have been examined in previous research and found that many of these beliefs were prevalent. A substantial proportion of the sample endorsed beliefs related to a general HIV/AIDS government conspiracy and, to a lesser extent, had suspicions about new treatments for HIV. Several beliefs were endorsed by the majority of the sample. More extreme beliefs related to genocidal conspiracies were endorsed at lower, albeit sizable, rates. For example, 26% some-

Table 2. HIV/AIDS Conspiracy Beliefs Endorsed by Study Sample, N=71

	Mean (SD)	Disagree Strongly (%)	Disagree Somewhat (%)	No Opinion (%)	Agree Somewhat (%)	Agree Strongly (%)
Government Conspiracy Beliefs						
A lot of information about AIDS is being held back from the public.	3.74 (1.43)	10.0	18.6	1.4	27.1	42.9
HIV is a manmade virus.	3.13 (1.68)	29.7	10.9	9.4	17.2	32.8
AIDS is a real public health threat.	4.79 (0.72)	2.8	0.0	0.0	9.9	87.3
There is a cure for AIDS, but it is being withheld from the poor.	3.19 (1.58)	21.4	21.4	4.3	22.9	30.0
The government is telling the truth about AIDS.	2.60 (1.52)	35.3	22.1	2.9	26.5	13.2
AIDS is a form of genocide against African Americans.	2.14 (1.48)	52.2	18.8	2.9	14.5	11.6
AIDS was created by the government to control the African-American population.	2.06 (1.50)	59.4	11.6	5.8	10.1	13.0
Treatment Conspiracy Beliefs						
The medicine used to treat HIV causes people to get AIDS.	1.82 (1.08)	56.1	16.7	18.2	7.6	1.5
The medicine that doctors prescribe to treat HIV is poison.	1.83 (1.19)	58.5	15.4	16.9	3.1	6.2
People who take the new medicines for HIV are human guinea pigs for the government.	2.87 (1.58)	30.4	17.4	8.7	21.7	21.7

what or strongly believed that, "AIDS is a form of genocide against African Americans," and 23% somewhat or strongly agreed that "AIDS was created by the government to control the African-American population." These results resemble those of previous research. In particular, almost 27% of respondents in a door-to-door survey of black households agreed that, "HIV/AIDS is a manmade virus that the federal government made to kill and wipe out black people,"[12] and 20% of African-American respondents to a national telephone survey endorsed the belief, "The government is using AIDS as a way of killing off minority groups."[10]

Belief in HIV/AIDS treatment conspiracies was associated with more positive attitudes toward condoms and a greater likelihood of condom use in the future. Such beliefs also were marginally associated with recent condom use. We speculate that HIV/AIDS treatment conspiracy beliefs tap into broad negative attitudes about the health care system. Individuals who do not trust new treatments for HIV may be motivated to use condoms in order to avoid those treatments and any contact with health care providers. Because our study was cross-sectional, we could not examine this hypothesis. Future research should test this hypothesis directly by examining the prospective relationships among general attitudes toward the health care system, HIV/AIDS conspiracy beliefs, and a range of sexual behaviors and attitudes. Negative attitudes toward health care could engender treatment-related conspiracy beliefs, which, in turn, could be related to greater condom use over time.

Although our results indicated positive relationships between HIV/AIDS treatment conspiracy beliefs and attitudes and intentions regarding condom use, it would be premature to conclude that individuals who hold treatment conspiracy beliefs are more receptive to prevention messages. We also found that greater endorsement of HIV/AIDS government conspiracy beliefs was associated with more negative beliefs about condoms for contraceptive use and having larger numbers of sexual partners in the recent past. Thus, the findings of the present study are complex, and further research in this area is warranted. Nevertheless, regardless of the type of relationship between conspiracy beliefs and sexual behavior and attitudes, our results demonstrate that a sizable proportion of African Americans may endorse conspiracy beliefs. This suggests the importance of considering the role of conspiracy beliefs when designing culturally appropriate HIV prevention interventions and educational campaigns.

To achieve the greatest success, HIV prevention messages addressing conspiracy beliefs may need to be delivered by trusted and respected members of African-American communities. Previous research has demonstrated the efficacy of such community-based, peer-delivered interventions in reducing risky sexual behaviors[20-23]. Peer educators may be seen as more credible than members of the public health system, who are unknown to most individuals in the community. Moreover, peer educators can provide accepting environments in which to address conspiracy beliefs, as well as to discuss the historical and present-day discrimination in health care from which these beliefs may have arisen.

Furthermore, longitudinal research is needed to

Table 3. Associations Between Conspiracy Beliefs and Sexual Risk-Related Attitudes, Intentions, and Behaviors, and Reproductive Health Care Utilization

	HIV/AIDS Government Conspiracy Scale	HIV/AIDS Treatment Conspiracy Scale
Quality of Condoms as Birth Control (n=71)[a]	-0.36**	-0.10
Condom Attitudes Scale (n=66)[a]	0.02	0.25*
Condom Use Intentions (n=65)[a]	0.11	0.25*
Condom Use, Past 3 Mos. (never vs. sometimes/always; n=44)[b]	0.24	0.27+
Number Partners, Past 3 Mos. (n=65)[a]	0.26*	0.11
Number Partners, Lifetime (n=58)[a]	-0.04	-0.15

** p<0.01 * p<0.05 + p<0.10
a Pearson correlations presented
b Point-biserial correlations presented

explore the origins and correlates of conspiracy beliefs, such as experiences with discrimination in health care and in everyday life. Because conspiracy beliefs are hypothesized to stem from chronic experiences of discrimination, a prospective model could be tested to examine the dynamic relationships among perceived discrimination and belief in conspiracies, as well as the long-term effects of these beliefs on sexual behavior.

The findings of the present study should be viewed with caution due to a number of methodological limitations. Although a national random sample was used, this study was exploratory, and only 71 individuals were surveyed. Thus, the analyses were underpowered for the detection of small or medium effects, and the results should therefore be considered preliminary. Future research with larger samples is needed to examine the robustness of the associations presented. Furthermore, the study design was cross-sectional, and therefore conclusions about causality cannot be drawn. For example, without a prospective study, it is impossible to determine whether treatment-related conspiracy beliefs lead to greater condom use and more positive attitudes about condoms, or whether conspiracy beliefs derive from previous HIV-related behaviors and attitudes. A dynamic relationship possibly exists, with conspiracy beliefs and sexual behaviors and attitudes influencing each other over time.

Another limitation is related to the telephone survey methodology. Use of a telephone survey is a strength, in that we were able to obtain participant responses anonymously, without the social desirability concerns of a face-to-face interview. However, we were unable to survey individuals without a telephone. Thus, we could have missed the poorest individuals in the sampling area—those who may have had the greatest risk for HIV[24]. Future research could address this concern with the use of multiple methodologies (e.g., both phone and face-to-face surveys) to ensure that individuals with more diverse socioeconomic status are represented. In addition, in the present study, we were interested in examining conspiracy beliefs among African Americans, and we therefore did not survey whites or other racial/ethnic groups. Examining whether the association between conspiracy beliefs and sexual risk behavior differs by race/ethnicity could provide useful information for developing culturally relevant interventions.

A larger sample would have allowed for in-depth analysis of subsamples by sociodemographic characteristics, such as marital/cohabitation status. In particular, lack of condom use may have a different meaning among those who are not, versus those who are, in a committed relationship. For example, prior research shows that individuals in committed relationships may choose not to use condoms, because they do not consider themselves to be at risk for HIV[25,26], because they believe that condom use is unnecessary in monogamous relationships[27-29], or because they associate condom use with distrust between partners[30-32]. Accordingly, condom use has been found to be less likely with primary, than with casual, partners[33-36]. However, research shows that individuals who believe that they are in a committed relationship may still be at risk for HIV, via their partner's risky behavior[37,38]. Thus, it is important to examine the sexual behaviors among all individuals regardless of relationship status.

Despite the limitations of the present study, almost no prior work has investigated how HIV/AIDS conspiracy beliefs might influence HIV prevention efforts in African-American communities. Although our sample is small, the present research provides an initial demonstration of the relationship of conspiracy beliefs to a range of prevention-relevant attitudes and behaviors. Moreover, our findings, combined with those of previous research, show that a substantial proportion of African Americans endorse HIV/AIDS conspiracy beliefs and suggest that culturally tailored interventions addressing such beliefs are essential for HIV prevention efforts in African-American communities.

ACKNOWLEDGEMENT

Seed money for this research was provided by the Research Program on Women's Health at the Center for the Study of Women in Society, University of Oregon. We thank Pamela Jull, PhD, and her staff at Applied Research Northwest for conducting the telephone interviews, and Douglas Delahanty, Linda Gallo, and Elizabeth Klonoff for helpful comments on an earlier version of this manuscript.

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